# City of Takoma Park

Dear City Staff:

We are very pleased that the City of Takoma Park can offer you a comprehensive and competitive benefit program.

Our program achieves this by featuring comprehensive coverage, flexibility and choice. If you are a regular full-time or regular part-time employee and are scheduled to work a minimum of twenty (20) hours per week, you are eligible for all of the benefits described in this booklet, effective on your date of hire, unless otherwise noted.

We hope that this benefit program reassures you and your family that the City of Takoma Park wants to create a positive and supportive work environment for you – an environment that allows you to dedicate your efforts toward our mission of providing timely and effective services to all of our customers.

We also added the convenience of the Employee Benefit Center (EBC) website. You now have 24/7 on line access to employee benefits at www.benefitspassport.com. Username: city  Password: takoma

And soon we will launch Employee Access/Intranet. Employees will be able to access, edit, their own employee information - anytime, anywhere. You will have access to view and in some cases edit personal information through a web browser interface. You will be able to obtain benefits and keep attendance history, deductions and copies of your payroll check.

Should you need further assistance with your benefits, please do not hesitate to call Human Resources at 301-891-7203.

Sincerely,

Karen Hampton
Human Resources Manager

Johnathan Edmund
Human Resources Analyst

# BENEFIT OVERVIEW

### Eligibility Requirements
New regular full-time employees or regular part-time employees who work twenty (20) hours or more, may enroll in the medical, dental and vision plans effective with the date of hire, unless otherwise noted.

### Medical-UnitedHealthcare
Employees may chose from the UnitedHealthcare HMO Choice Plan or the Choice Plus Plan.

### Dental- UnitedHealthcare
Employees may choose between two UnitedHealthcare PPO dental plans.

### Vision- Vision Service Plan
Employees are offered an additional vision plan. (The UnitedHealthcare medical plan includes a routine eye exam.)

### Life/AD&D and Long-Term Disability- Aetna - City funded 100%
Enrollment in these plans is automatic and premiums are paid entirely by the City of Takoma Park.

### Supplemental Insurance- Colonial Life
Employees are offered additional insurance for: Disability, Accident, Cancer, Universal Life and Term Life Insurance on a voluntary basis. Enrollment in these plans is voluntary and premiums are paid entirely by the employee.

### State of Maryland Retirement
All benefit-eligible employees (except sworn officers) are automatically enrolled in this plan. Employees are required to contribute 5% of their earnable compensation to the retirement system.

### Takoma Park Police Retirement
All Takoma Park sworn officers are automatically enrolled in this plan. Sworn officers are required to contribute 7% of their earnable compensation to the retirement system.

### 457 Deferred Compensation Plan
The City of Takoma Park sponsors a 457 Retirement Plan through I.C.M.A. with a loan program. Employees contribute to this plan unless otherwise noted.

### Section 125 Premium Conversion Plan
To help reduce your benefit costs, City of Takoma Park sponsors a Section 125 Plan. This plan allows you to use pre-tax dollars to pay for any required contributions to medical coverage.

### Flexible Spending Accounts (FSA)
The Medical Care FSA helps you cover those medically necessary expenses not covered, or only partially covered, by your health, dental and/or vision insurance. The Dependent Care FSA helps you pay for dependent care expenses for a child or elderly adult.

### HIPAA- Release of Protected Health Information
Authorization from employees to allow Human Resources to investigate claim issues on their behalf.

# BENEFIT OVERVIEW continued

### COBRA
Continuation of group health coverage for employees and dependents losing coverage due to a qualifying event.

### Tuition Reimbursement
Employees are eligible to apply for tuition reimbursement for educational expenses in a job related field. Reimbursement must be pre-approved and will be paid upon receiving a passing grade for course credit up to the per credit cost set forth by the University of Maryland College Park. A maximum of 6 credits will be allowed per college semester. See Personnel Regulation 91-4.

### Employee Assistance Program (EAP) - City funded 100%
Employees and their family members are eligible to confidentially take advantage of full counseling services through Magellan EAP at no cost. Coverage has been extended to employees six (6) months after separating from employment at no cost. You can reach the EAP counselor at 1-800-523-5668 or Hearing Impaired/TTY 1-800-882-7610.

### Direct Deposit
Direct deposit of bi-weekly pay is available for all employees.

### Legal Resources Group Legal Plan
Legal Resources provides a unique voluntary employee benefit. It is a legal services plan which enables employees and their dependents to select a highly regarded local law firm to provide legal coverage for a wide range of issues. You choose a law firm from the Legal Resources network and you call them directly. Most services are covered at 100%, meaning the subscriber and their dependents pay no attorney fees and other legal matters are covered at a 25% discount

There are no co-payments, no deductibles and no restrictions on use for all the fully covered services. To learn more about this benefit and see a brief video describing the plan, visit the Legal Resources website at www.legalresourcesplan.com.

### Montgomery County Employees Federal Credit Union
Employees and their family members are eligible for membership and to receive all the benefits associated with the Credit Union.

### Employees are also eligible for the following additional benefits:
- Training Opportunities
- Professional Membership
- Service & Recognition Awards
- Employee Annual Social Events
- Free Membership to the Takoma Park Recreation Center
- Police Dispatcher Training Pay
- Multi-Lingual Pay Differential

### Holidays
Each year, while actively working, you will be entitled to receive the following 10 1/2 paid holidays:

- New Year's Day
- Martin Luther King, Jr. Day
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Veteran's Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Eve (½ day)
- Christmas Day

# BENEFIT OVERVIEW continued

## Personal Leave

Full-time employees earn personal leave according to the following schedule:

| Length of Service | Number of Personal Days |
|---|---|
| 0-5 years | 1 |
| Over 5-10 years | 2 |
| Over 10-15 years | 3 |
| Over 15-20 years | 4 |
| Over 20+ years | 5 |

Employees covered by the UFCW, Local 400 agreement earn personal leave after probation according to the following schedule:

| Length of Service | Number of Personal Days |
|---|---|
| 1-5 years | 1 |
| Over 5-10 years | 2 |
| Over 10-15 years | 3 |
| Over 15-20 years | 4 |
| Over 20+ years | 5 |

Personal days must be used in the year earned (use or lose). Employees covered by the AFSCME contract and not covered by a collective bargaining unit may use personal leave in hourly increments. Part-time employees earn personal days on a pro-rata basis.

## Sick Leave

Full-time employees earn sick leave at the rate of 10 hours per month (15 days per year) with unlimited accumulation. Part-time employees earn sick leave on a pro-rated basis.

## Vacation

Full-time employees earn vacation according to the following schedule:

| Length of Service | Monthly Accrued | Annual Accrued |
|---|---|---|
| 0-5 years | 8 hours (1 day) | 12 days |
| Over 5-10 years | 12 hours (1 1/2 days) | 18 days |
| Over 10+ years | 16 hours (2 days) | 24 days |

Vacation carry over into a new calendar year is limited to 30 days.

Part-time employees earn vacation on a pro-rated basis.

New employees may not use annual leave during the first 90 days of employment.

Annual leave may be used in hourly increments.

**For more information on Leave benefits, see the appropriate governing documents.**

## Domestic Partner Benefits

The City of Takoma Park recognizes the diversity of families and extends health benefits to domestic partners and their dependents.

## Benefits

Always check your payroll stub to assure appropriate deductions are being taken. Make every effort to resolve benefit disputes within 60 days of when you were to receive the benefit in question.

# BENEFIT OVERVIEW continued

## CHILDREN'S HEALTH INSURANCE PROGRAM

Depending on your income and family size, medical coverage may be available to your children through the federal Children's Health Insurance Program (CHIP), which is administered through each state. If you qualify for this program, you will pay nothing (or a small amount) for coverage for children and pregnant women. **In 2009, the Children's Health Insurance Program Reauthorization Act made various changes in CHIP.** The law now permits two new special enrollment events in an employer's group health plan.

Special Enrollment:Employees and dependent(s) may enroll in an employer sponsored group health plan if:

1. Their coverage under Medicaid or SCHIP terminates due to the loss of eligibility; or
2. They become eligible for premium assistance from the State under a Medicaid or SCHIP program.

This is an abbreviated summary of this law. For additional information visit the main website at **www.insurekidsnow.gov or www.cms.hhs.gov/home/chip or contact 877-KIDS-NOW (877-543-7669).**

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This booklet provides a brief summary of the plans offered by the City of Takoma Park and in no way serves as the Summary Plan Description or plan document for the plans. If there are any discrepancies between this booklet and the plan documents, the plan documents will govern. You may contact the City of Takoma Park Human Resources if you wish to see the plan documents. v. 8.09 

# MEDICAL BENEFITS UnitedHealthcare

| | Choice - Plan 9DG<br>Member Responsibility<br>In-Network Only[1] |
|---|---|
| **Deductible** | None |
| **Coinsurance** | None |
| **Out-of-Pocket Limit** - Individual/Family | $1,500/$3,000 |
| **Lifetime Maximum Benefit** | Unlimited |
| **Office Visits** - Preventive Care | |
| Physician | $10 |
| Specialist | $15 |
| Well Child Care (includes immunizations) | $10 PCP/$15 Specialist |
| **Office Visits** - Sickness and Injury | $10 PCP/$15 Specialist |
| **Diagnostic Services** (outpatient) | |
| Preventive Lab, X-ray and Diagnostics | No charge |
| CT, PET, MRI, MRA and Nuclear Medicine | No charge |
| **Hospitalization** - Inpatient Stay | No charge |
| **Outpatient Surgery** | No charge |
| **Professional Fees** - Surgical and Medical | No charge |
| **Maternity** | |
| First OB Visit | $10 PCP/$15 Specialist |
| Delivery and Inpatient Services | No charge |
| **Emergency Services** | |
| Emergency Health | $50 |
| Urgent Care Center | $50 |
| **Physical, Speech and Occupational Therapy**[2] | $10 |
| **Chiropractic Treatment**[2] | $10 |
| **Mental Health/Substance Abuse**[3] | |
| Inpatient Services | No charge |
| Outpatient Visits: 1-5 | 20% of eligible expenses |
| Outpatient Visits: 6-30 | 35% of eligible expenses |
| Outpatient Visits: 31+ | 50% of eligible expenses |
| **Durable Medical Equipment**[4] | No charge |
| **Prescription Drugs** | **Tier 1/Tier 2/Tier 3** |
| Retail - up to a 31-day supply | $5/$15/$30 |
| Maintenance - up to a 90-day supply Retail or Mail Order | $12.50/$37.50/$75 |
| **Vision** | |
| Eye Exam (1 exam every 2 years) | $10 |

PCP = Primary Care Physician

1 See any physician or other health care professional from the UHC network, including specialist, without a referral. For benefits to apply, UnitedHealthcare Choice providers must be used for care.
2 Limited to 20 visits each per year.
3 Prior authorization is required from the Mental Health/Substance Abuse Designee.
4 Limited to $5,000 per year; Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years.

# MEDICAL BENEFITS UnitedHealthcare

## Choice Plus - Plan 7EF

| Member Responsibility | In-Network[1] | Out-of-Network[2] |
|---|---|---|
| **Deductible** - Individual/Family | None | $200/$400 |
| **Coinsurance** | None | 20% |
| **Out-of-Pocket Limit** - Individual/Family | $1,500/$3,000 | $3,000/$6,000 |
| **Lifetime Maximum Benefit** | $5,000,000 per covered person (combined) | |
| **Office Visits** - Preventive Care | | |
| Physician/Specialist | $10/$15 | Ded., then 20% |
| Well Child Care (includes immunizations) | $10 PCP/$15 Specialist | 20% (no deductible) |
| **Office Visits** - Sickness and Injury | $10 PCP/$15 Specialist | Ded., then 20% |
| **Diagnostic Services** (outpatient) | | |
| Preventive Lab, X-ray and Diagnostic | No charge | Ded., then 20% |
| CT, PET, MRI, MRA and Nuclear Medicine | No charge | Ded., then 20% |
| **Hospitalization** - Inpatient Stay | No charge | Ded., then 20%[3] |
| **Outpatient Surgery** | No charge | Ded., then 20% |
| **Professional Fees** - Surgical and Medical | No charge | Ded., then 20% |
| **Maternity** | | |
| First OB Visit | $10 PCP/$15 Specialist | Ded., then 20% |
| Delivery and Inpatient Services | No charge | Ded., then 20%[3] |
| **Emergency Services** | | |
| Emergency Health | $50 | $1003 |
| Urgent Care Center | $35 | Ded., then 20% |
| **Physical, Speech and Occupational Therapy**[4] | $10 | Ded., then 20%[3] |
| **Chiropractic Treatment**[4] | $10 | Ded., then 20%[3] |
| **Mental Health/Substance Abuse**[5] | | |
| Inpatient Services | No charge | Ded., then 20% |
| Outpatient Visits: 1-5 | 20% of eligible expenses | Ded., then 20% of eligible expenses |
| Outpatient Visits: 6-30 | 35% of eligible expenses | Ded., then 35% of eligible expenses |
| Outpatient Visits: 31+ | 50% of eligible expenses | Ded., then 50% of eligible expenses |
| **Durable Medical Equipment**[6] | No charge | Ded., then 20%[7] |
| **Prescription Drugs** | **Tier 1/Tier 2/Tier 3** | |
| Retail - up to a 31-day supply | $5/$15/$30 | $5/$15/$30 |
| Maintenance - up to a 90-day supply Retail or Mail Order | $12.50/$37.50/$75 | $12.50/$37.50/$75 |
| **Vision** | | |
| Eye Exam (1 exam every 2 years) | $10 | Ded., then 20% |

PCP = Primary Care Physician

1 See any physician or other health care professional from the UHC network, including specialist, without a referral. For benefits to apply, UHC Choice providers must be used for care.

2 For services received from a NON-participating UHC network provider, member is responsible for 100% of charges above the Eligible Expenses.

3 Pre-service notification is required for certain services. Regarding Emergency Health Services, pre-service notification is required if results in an Inpatient Stay.

4 Limited to 20 visits each per year.

5 Prior authorization is required from the Mental Health/Substance Abuse Designee.

6 Limited to $5,000 per year; Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years.

7 Pre-service notification is required for Durable Medical Equipment in excess of $1,000.

# DENTAL BENEFITS UnitedHealthcare

## PPO - Plan P7101[1]

**Member Responsibility**

| | In-Network | Out-of-Network[2] |
|---|---|---|
| **Class I - Preventive & Diagnostic** | Covered in full | 20% of AC |
| Oral Exam (limited to 2 times per consecutive 12 months) | | |
| Prophylaxis (cleanings limited to 2 times per consecutive 12 months) | | |
| Fluoride Treatment (limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months) | | |
| Sealants (limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months) | | |
| Space Maintainers (for covered persons under the age of 16 years, limited to 1 per consecutive 60 months) | | |
| Radiographs (bite-wing: limited to 1 series of films per calendar year; complete/panorex: limited to 1 time per consecutive 36 months) | | |
| Lab and Other Diagnostic Tests | | |
| **Class II - Basic Services** | Ded., then 20% | Ded., then 40% of AC |
| Restorations (amalgams or composite - multiple restorations on one surface will be treated as a single filling) | | |
| General Services (including emergency treatment - pallative treatment: covered as a separate benefit only if no other service was done during the visit other than x-rays; general anesthesia: when clinically necessary) | | |
| Simple Extractions (limited to 1 time per tooth/lifetime) | | |
| **Class III - Major Services** | Ded., then 50% | Ded., then 60% of AC |
| Oral Surgery (includes surgical extractions) | | |
| Periodontics (perio surgery: limited to 1 quadrant or site per consecutive 36 months per surgical area; scaling and root planing: limited to 1 time per quadrant per consecutive 24 months; periodontal maintenance: limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement) | | |
| Endodontics | | |
| Inlays/Onlays/Crowns (limited to 1 time per tooth per consecutive 60 months) | | |
| Dentures and other Removable Prosthetics (full denture/partial denture: limited to 1 per consecutive 60 months; no additional allowances for precision or semi-precision attachments; Occlusal Guard: covered only if prescribed to control habitual grinding and limited to 1 guard every consecutive 36 months) | | |
| Fixed Partial Dentures (Bridges - once per tooth per consecutive 60 months) | | |
| **Class IV - Orthodontic** (Child up to age 19) | 50% | 50% of AC |
| **Deductible** | | |
| Class I | None | None |
| Classes II and III | $50 Ind./$150 Family | $100 Ind./$300 Family |
| Class IV | None | None |
| **Maximum** | | |
| Classes I, II and III | $1,000/person/calendar year | $1,000person/calendar year |
| Class IV | $1,000/person/lifetime | $1,000/person/lifetime |

AC = Allowed Charge

1 A pre-treatment estimate is recommended for any service estimated to costs over $500.
2 When choosing a non-participating dentist, members may be responsible for amounts over the allowed charge plan limits, therefore balance billing may apply.

# DENTAL BENEFITS UnitedHealthcare

## PPO - Plan P7100[1]

**Member Responsibility**

| | In-Network | Out-of-Network[2] |
|---|---|---|
| **Class I - Preventive & Diagnostic** | Covered in full | Covered in full to AC |
| Oral Exam (limited to 2 times per consecutive 12 months)<br>Prophylaxis (cleanings limited to 2 times per consecutive 12 months)<br>Fluoride Treatment (limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months)<br>Sealants (limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months)<br>Space Maintainers (for covered persons under the age of 16 years, limited to 1 per consecutive 60 months)<br>Radiographs (bite-wing: limited to 1 series of films per calendar year; complete/panorex: limited to 1 time per consecutive 36 months)<br>Lab and Other Diagnostic Tests | | |
| **Class II - Basic Services** | Ded., then 20% | Ded., then 20% of AC |
| Restorations (amalgams or composite - multiple restorations on one surface will be treated as a single filling)<br>General Services (including emergency treatment; pallative treatment: covered as a separate benefit only if no other service was done during the visit other than x-rays; general anesthesia: when clinically necessary)<br>Simple Extractions (limited to 1 time per tooth/lifetime) | | |
| **Class III - Major Services** | Ded., then 50% | Ded., then 50% of AC |
| Oral Surgery (includes surgical extractions)<br>Periodontics (perio surgery: limited to 1 quadrant or site per consecutive 36 months per surgical area; scaling and root planing: limited to 1 time per quadrant per consecutive 24 months; periodontal maintenance: limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement)<br>Endodontics<br>Inlays/Onlays/Crowns (limited to 1 time per tooth per consecutive 60 months)<br>Dentures and other Removable Prosthetics (full denture/partial denture: limited to 1 per consecutive 60 months; no additional allowances for precision or semi-precision attachments; Occlusal Guard: covered only if prescribed to control habitual grinding and limited to 1 guard every consecutive 36 months)<br>Fixed Partial Dentures (Bridges - once per tooth per consecutive 60 months) | | |
| **Class IV - Orthodontic** (Child up to age 19) | 50% | 50% of AC |
| **Deductible** | | |
| Class I | None | None |
| Classes II and III | $50 Ind./$150 Family | $50 Ind./$150 Family |
| Class IV | None | None |
| **Maximum** | | |
| Classes I, II and III | $1,000/person/calendar year | $1,000person/calendar year |
| Class IV | $1,000/person/lifetime | $1,000/person/lifetime |

AC = Allowed Charge

1 A pre-treatment estimate is recommended for any service estimated to costs over $500.
2 When choosing a non-participating dentist, members may be responsible for amounts over the allowed charge plan limits, therefore balance billing may apply.

# VISION BENEFITS Vision Service Plan

| | Your VSP Vision Benefits<br>Member Responsibility<br>In-Network<br>Participating VSP Doctor | <br><br>Out-of-Network<br>Reimbursement |
|---|---|---|
| **Eye Exam** (every 24 months) | Covered in full | Up to $52 |
| **Prescription Glasses** (every 24 months) | | |
| Lenses | | |
| Single Vision | Covered in full | Up to $55 |
| Lined Bifocal | Covered in full | Up to $75 |
| Lined Trifocal | Covered in full | Up to $95 |
| Frame | Frame of your choice up to $120 allowance; Plus 20% off any out-of-pocket costs. | Up to $45 |
| | **~OR~** | |
| **Contact Lens Care** (every 24 months) | Up to $120 allowance for contacts and the contact lens exam (fitting and evaluation) | Up to $105 |

**Extra Discount and Savings**

Glasses and Sunglasses

- ~Average 35% - 40% savings on all non-covered lens options
- ~30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam.

Contacts

- ~15% off cost of contact lens exam (fitting and evaluation)

Laser Vision Correction

- ~Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.
- ~After surgery, use your fame allowance (if eligible) for sunglasses from any VSP doctor.

# City of Takoma Park
# Health Insurance Premiums

*For Persons covered by the Collective Bargaining Agreement with AFSCME Local 3399*
*For City Staff not covered by a Collective Bargaining Agreement*
*Police Meet and Confer Group*
*Local 400*

**July 1, 2009 - June 30, 2010**

**The Employer's Contribution is set at the cost of the UHC-HMO Choice 9DG - Plan Rx Co-Pay $5/$15/$30 and $50 Emergency Room as follows:**

| Status | Monthly Cost | City's Monthly Contribution | Employee's Monthly Contribution |
|---|---|---|---|
| Single | $471.07 | $471.07 | $0.00 |
| Parent/Child | $880.89 | $704.71 | $176.18 |
| Parent/Child(ren) | $880.89 | $704.71 | $176.18 |
| Husband/Wife | $1,050.48 | $840.38 | $210.10 |
| Family | $1,380.22 | $1,104.18 | $276.04 |

## UHC - HMO Choice 9DG

| Status | Monthly Cost | City's Monthly Contribution | Employee's Monthly Contribution |
|---|---|---|---|
| Single | $471.07 | $471.07 | $0.00 |
| Parent/Child | $880.89 | $704.71 | $176.18 |
| Parent/Child(ren) | $880.89 | $704.71 | $176.18 |
| Husband/Wife | $1,050.48 | $840.38 | $210.10 |
| Family | $1,380.22 | $1,104.18 | $276.04 |

## UHC - Choice Plus 7EF

| Status | Monthly Cost | City's Monthly Contribution | Employee's Monthly Contribution |
|---|---|---|---|
| Single | $494.18 | $471.07 | $23.11 |
| Parent/Child | $924.12 | $704.71 | $219.41 |
| Parent/Child(ren) | $924.12 | $704.71 | $219.41 |
| Husband/Wife | $1,102.03 | $840.38 | $261.65 |
| Family | $1,447.96 | $1,104.18 | $343.78 |

**Dental and Vision Care coverage is available as follows:**

## UHC - Passive PPO Option 2 - Plan #7101

| Status | Monthly Cost | City's Monthly Contribution | Employee's Monthly Contribution |
|---|---|---|---|
| Single | $16.57 | $16.57 | $0.00 |
| Parent/Child | $33.09 | $26.47 | $6.62 |
| Husband/Wife | $33.09 | $26.47 | $6.62 |
| Family | $62.71 | $50.17 | $12.54 |

## UHC - Passive PPO Option 2 - Plan #7100

| Status | Monthly Cost | City's Monthly Contribution | Employee's Monthly Contribution |
|---|---|---|---|
| Single | $28.66 | $16.57 | $12.09 |
| Parent/Child | $56.53 | $26.47 | $30.06 |
| Husband/Wife | $56.53 | $26.47 | $30.06 |
| Family | $100.31 | $50.17 | $50.14 |

## Vision Care

| Status | Monthly Cost | City's Monthly Contribution | Employee's Monthly Contribution |
|---|---|---|---|
| Single | $4.14 | $4.14 | $0.00 |
| Parent/Child | $5.88 | $4.70 | $1.18 |
| Husband/Wife | $5.88 | $4.70 | $1.18 |
| Family | $10.53 | $8.42 | $2.11 |

# WHAT IS BALANCE BILLING?

Members need to be aware of how claims will be calculated when Out-of-Network benefits are used. There could be additional fees and paperwork if care is received from providers that do not participate with your insurance plan.

There is a maximum plan allowance that POS and PPO carriers will pay for any given procedure. Participating providers will submit claim forms for members and are under contract to accept the plan allowance determined by the carrier and cannot bill the member for the difference between the actual charge and the plan allowance. Participating providers simply disregard charges that exceed the plan allowance when processing your bill.

You may need to complete and submit claim forms for providers that do not participate with your insurance plan. **Non-participating providers will bill members for the difference between the actual charge and the plan allowance. These charges will not be applied to the member's deductible or out-of-pocket maximums.**

**In-Network Example:** Jane goes to a participating provider. Her doctor charges $200 for a procedure and the plan allowance is $150. Jane's bill would be calculated like this:

| | |
|---|---|
| Doctor's Fee: | $200 |
| Plan Allowance: | $150 |
| Member Copay: | $10 |
| Amount paid to Provider: | $140 |
| **Balance of Bill:** | **$50*** |

**Written off by the participating provider and not the member's responsibility.*

In this example Jane's responsibility is her $10 copay since a participating provider was used. **Her total out of pocket is $10.**

**Out-of-Network Example:** Jane goes to a non-participating provider. Her doctor charges $200 for a procedure and the plan allowance is $150. Jane has met all of her annual deductible. Jane's bill would be calculated like this:

| | |
|---|---|
| Doctor's Fee: | $200 |
| Plan Allowance: | $150 |
| Member's 20% Coinsurance: | $30 |
| Amount paid to Provider: | $120 |
| **Balance of Bill:** | **$50*** |

**Not written off by the non-participating provider and now the member's responsibility.*

In this example Jane's responsibility is her 20% coinsurance amount ($30) plus the balance between the Doctor Fee and the Plan Allowance ($50). **Her total out of pocket is $80.**

# LIFE/ACCIDENTAL DEATH & DISMEMBERMENT

## Aetna

Life insurance is offered to all full-time employees. The employee life insurance plan provides a death benefit equal to one times the employee's basic annual earnings to a maximum of $50,000. Benefits are subject to the age reduction rule: by 65% at age 65; by 40% at age 70; by 25% at age 75. Benefits will terminate upon retirement.

The benefit paid to the employee for Accidental Dismemberment of more than one of the listed losses resulting from the same accident is 100% of the life coverage amount. The benefit paid to the employee for one of the listed losses is 50% of the life coverage amount. (See your Certificate of Group Life Insurance for a complete listing of Accidental Dismemberment losses.)

All insurance amounts are issued on a guaranteed basis at the time of the employee's initial eligibility. Since the City of  Takoma Park pays the entire premium for the Life/AD&D plan, employees cannot waive coverage and enrollment in the plan is automatic.

See your benefits contract for additional detailed information.

# LONG-TERM DISABILITY Aetna

Long-Term Disability is offered to all full-time employees. LTD benefits provide income replacement when you are unable to work due to a non-occupational illness or injury.

Employees receive Long-Term Disability benefits in the amount equal to 60% of their basic monthly earnings up to a maximum of $5,000 per month. Benefits will become effective after 180 days of disability due to an accidental injury or sickness. Benefits will be payable up to age 65.

All insurance amounts are issued on a guaranteed basis at the time of the employee's initial eligibility. Since the City of Takoma Park pays the entire premium for the Long-Term Disability plan, employees cannot waive coverage and enrollment in the plan is automatic.

See your benefits contract for additional detailed information.

# SUPPLEMENTAL INSURANCE Colonial Life

Employees may purchase Supplemental Insurance for Disability, Accident, Cancer, Universal Life and Term Life Insurance on a pre-tax payroll deduction basis. You may apply for coverage for yourself, your spouse and children.

**Disability Coverage:** Provides monthly benefits to replace a portion of your income if you are unable to work due to an illness or accident (including maternity).

**Accident Coverage:** Provides help with out-of-pocket expenses related to a covered accident.

**Cancer Coverage:** Provides benefits to offset both the direct and indirect costs related to the treatment of cancer. In addition, benefits are paid directly to you for yearly cancer screening tests.

**Universal Life Insurance:** Provides financial security with flexible coverages and premiums to meet your needs, while accumulating cash value.

**Term Life Insurance:** Provides larger amounts of basic insurance when budgets are limited.

You may continue your coverage when you retire or change jobs, with no increase in premiums.

Unless specifically noted, all benefits will be paid directly to you.

Contact the Human Resources Department for information on how to enroll in any of the available Supplemental Insurance plans.

# STATE OF MARYLAND RETIREMENT

All benefit-eligible employees (except for sworn officers) are automatically enrolled in the Maryland State Retirement System. Employees are required to contribute 5% of their earnable compensation to the retirement system.

# TAKOMA PARK POLICE RETIREMENT

All Takoma Park sworn officers are automatically enrolled in the Takoma Park Police Retirement System. Sworn officers are required to contribute 7% of their earnable compensation to the retirement system.

# 457 DEFERRED COMPENSATION I.C.M.A.

## INVEST! WATCH YOUR SAVINGS GROW!

The City of Takoma Park's deferred compensation program has been established to provide employees with voluntary investment options designed to supplement their income at retirement. We now have a loan program under the Plan. For more information on loans go to www.icmarc.org.

The City's deferred compensation program is available through I.C.M.A Retirement Corporation and enables you to contribute money from your paycheck before federal and most state taxes are taken out. The pre-tax contributions lower your current income taxes which leaves more money in your paycheck. Maximum deferral percentages and dollar amounts are limited by IRS regulations.

The City will match an employees contribution to the I.C.M.A. 457 Deferred Compensation Plan up to 2% of the employees annual salary as of January 1.

The Contribution will be made in June and December.

This benefit applies to all employees who are covered by the Maryland State Retirement Plan and Crossing Guards.

**Contributions to 457 Deferred Compensation in lieu of Health Insurance Premiums:** City Staff who can show proof of health coverage from a source other than the City's group plan and sign the City's health insurance waiver form each year during open enrollment, may have an amount equal to the City's contribution for single health care deposited in their I.C.M.A. 457 Deferred Compensation Plan. This deposit will be made in June and December. This benefit applies to all employees who are eligible to receive health benefits, but does not include dental or vision insurance.

The effective date for this benefit is the date that the City's contributions are stopped but no earlier than March 1, 2003 (except for those already receiving this benefit).

To be eligible, you must apply for this benefit in the Human Resources Office.

# SECTION 125 PREMIUM CONVERSION PLAN

Employees may choose to pay for insurance premiums with pre-tax dollars by electing to participate in this plan. The amount due for your medical, dental and vision insurance premiums will be deducted from your gross pay before any taxes are deducted. By using pre-tax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck, resulting in more spendable income than if the same deductions were taken on an after tax basis.

**What is Section 125?**
Section 125 is part of the Internal Revenue Code that allows employees to convert a taxable cash benefit (salary) into non-taxable benefits. With this plan, you pay qualified benefit premiums before any taxes are deducted from your paycheck.

**Is Section 125 legal?**
Yes. In the Revenue Act of 1978, the United States Congress created and established Code Section 125 to make employee benefit programs more affordable.

**How can Section 125 work for me?**
Section 125 can make your benefit plans more affordable by paying for qualified benefits with pre-tax dollars. You can actually lower your taxable income, which means you pay less tax. Paying less tax usually results in more spendable income. When you take advantage of Section 125, you will actually get "more for your money."

**What are pre-tax dollars?**
Pre-tax dollars are the premiums you pay for qualified benefits under the Section 125 program. These premiums are deducted from your gross earnings before taxes are taken out.

**Am I required to participate?**
No, this is not required. If you wish to enroll in any of the benefit programs, which require an employee contribution, you may or may not elect to participate in the Section 125 program and pay for these benefits with pre-tax dollars.

**Can I enroll in Section 125 anytime?**
You must enroll in the benefits during the eligible enrollment period for the employee benefits offered. However, you can change your election during the Plan Year if you experience specified changes in status (see below).

**What is the Plan Year for Section 125 plans?**
The Plan Year is from July 1st to June 30th.

**Can I change my selections in Section 125 anytime I choose?**
No. You may only change selections during the applicable Plan Year for certain changes in status, such as marriage, divorce, death of a spouse or child, birth or adoption of a child, commencement or termination of spouse's employment, change in employment status by you or your spouse, loss of dependent child status and a change in the place of residence or work of the employee, spouse or dependent. You must notify the City of Takoma Park within 30 days of the change to make new benefit selections. New selections must be consistent with the status change.

# FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts let you set aside a portion of your paycheck to pay for certain health and dependent care expenses tax-free.

Contributions are deducted from paychecks before federal, state and Social Security taxes are computed and deposited into accounts in your name. Because you don't pay taxes on your contributions, you save money.

You pay for health and dependent care expenses as usual and get reimbursed by filing claim forms with the third party administrator. Eligible expenses must be incurred within the applicable contract year, regardless of when they are paid.

Health care and dependent care accounts are separate. You cannot transfer money from one account to another. Once you have designated a payroll deduction amount, this amount cannot be stopped or changed until the beginning of the next plan year unless you terminate employment or have a qualifying family status change.

**How much can I contribute?**
Each year you can deposit up to $5,000 to your Health Care Account to pay for expenses not covered under a medical plan for you, your spouse, and/or dependents. Each year you can deposit up to $5,000 to your Dependent Care Account to pay for expenses so that you and your spouse can work.

**Can I change my election?**
If you have a qualifying family status change, you have up to 30 days to submit a new enrollment form to Human Resources. You may also change the amount of your contributions or stop participating in the program during the annual Open Enrollment period.

**What else should I consider?**
Any money in your account that is not used for expenses incurred by the end of the plan year and for which a claim has not been submitted within a specified amount of time (usually 60 or 90 days) after the contract year, will be forfeited. This is required by IRS regulations.

Since there is some risk involved, you should put funds into a spending account only for those expenses you feel certain will be incurred. If you leave the City of Takoma Park for any reason, any money remaining in an account can still be used for expenses incurred while you were employed.

**Medical Spending Account**
The Medical Spending Account allows employees to pay for medical expenses that are not covered by health insurance with pre-tax dollars by making pre-tax contributions to the account. Reimbursement will be made as expenses are incurred and claims are presented. Covered expenses include, but are not limited to, annual deductibles, co-payments and out of pocket dental and vision expenses. You may use your FSA for your expenses as well as those of your spouse and other dependents. Employees may set aside up to $5,000 of salary per year.

# FLEXIBLE SPENDING ACCOUNTS continued

**Dependent Care Account**
The Dependent Care Account can be used to pay for the care of a dependent under 13 years of age, elderly parents or a spouse or other dependent who is incapable of self-care because of a physical or mental disability.

Your annual contribution cannot exceed your earned income, that of your spouse or $5,000 ($2,500 if you are married and file a separate tax return).

Eligible expenses include, but are not limited to, in-home services, out-of-home services, nursery or preschool expenses. School expenses for a child in grade school are not eligible. Payments to a relative for dependent care are eligible provided the relative is not a child of yours under age 19, or a dependent for whom you claim an exemption on your federal income tax return. Of utmost importance, you have until 90 days after the close of the contract year to submit expenses incurred during the plan year.

Please refer to your Summary Plan Description for more information and specific terms and conditions of the Plan or contact the Human Resources Department.

# HIPAA – RELEASE OF PROTECTED HEALTH INFORMATION

Due to restrictions imposed by the HIPAA Privacy Act (Gramm-Leach-Bliley Act) effective July 1, 2002, a member needing assistance with benefits and claims must either contact the carrier directly or file an ***Authorization for Release of Protected Health Information*** form to appoint another party to act in his or her behalf.

**It is recommended that each plan member complete the *Authorization for Release of Protected Health Information* form at time of enrollment** in order to appoint Human Resources as an approved representative. This will allow Human Resources to access your claim and benefit information for a period of one year. Members will continue to have direct access to their personal information by calling the toll-free number found on your carrier ID card.

**To ensure that assistance is available to you during the policy year, each insured member is advised to complete the *Authorization for Release of Protected Health Information* form.** If you choose not to complete this form at time of enrollment it will also be available for your future reference in your Human Resources Department.

The UnitedHealthcare release form can be found on page 16.

UnitedHealthcare®
A UnitedHealth Group Company

M.D. IPA℠ OPTIMUM CHOICE® MAMSI®

# Authorization for Release of Health Information

## (Expiration Following Disenrollment/Enrollee Initiated)

MD-Individual Practice Association, Inc., MAMSI Life and Health Insurance Company, and Optimum Choice, Inc. ("Health Plan") are able to release your health information if an Authorization for Release of Health Information (hereinafter referred to as "Release") is on file.

This Release will allow another person or an organization (including a spouse, family member, friend or employer benefit administrator, hereinafter referred to as "Recipient") to have access to your health information. Your health information is any information we maintain in the records of the Health Plan that relates to your past, present or future physical or mental health or medical condition, including any personal financial information.

A separate Release must be completed for each Recipient. If you are the subscriber to the policy (identified on your health plan identification card by the suffix "*01" in your member number), you may authorize a Release on behalf of each minor child/dependent on your policy. However, each member over the age of 18 years must complete and authorize his or her own Release.

### 1. Enrollee identification and contact information

The enrollee identified in this section is the person whose health information may be disclosed pursuant to this Release. Please provide your name and personal identification information, along with additional contact information in case we have any questions concerning this Release. If this Release is being completed for a minor child/dependent, please provide the name and personal identification information for the minor child/dependent.

Name: _____
Health Plan Identification Number : _____
Social Security Number: _____
Daytime Telephone Number : _____
Evening Telephone Number : _____
E-mail address : _____

### 2. Recipient Information

Health Plan may release your health information to the following individual or organization:

2.01 Name: _____
2.02 Address : _____
2.03 Date of Birth (required, if Recipient is an individual) _____
2.04 Health Plan Identification Number, if applicable: _____

### 3. Release limitations

Health Plan may release your health information subject to the following limitations (check all that apply):

3.01 _____ Complete authority
(may receive and make changes to all health information on file and may represent me in all matters with respect to my health insurance).

3.02 _____ Inquiry only
(may receive all health information on file, but may not make changes to health information on file).

3.03 _____ Primary Care Physician ("PCP") updates only.

3.04 _____ Other limited access (please specify): _____

4. **Expiration and revocation**

This Release will expire one year after termination of your health insurance coverage under your current Health Plan, or, if the enrollee is a minor, on such enrollee's 18th birthday. You may revoke this authorization at any time by notifying the Health Plan in writing, and such revocation will take effect once it is received by the Health Plan and will not affect any use or disclosure of information before the revocation is received by the Health Plan.

NOTE: If you live in the state of Pennsylvania, this Release shall expire on the second anniversary of the date of this Release as set forth below.

If you live in the state of Maryland, this Release shall expire on the first anniversary of the date of this Release as set forth below.

5. **Personal Representative** (If the person identified in Section 1 is signing this form, skip this section and go to Section 6.)

This Release may be completed and signed on behalf of any enrollee by the enrollee's Personal Representative. A Personal Representative is a person who has legal authority to act in health care matters on your behalf, including a person who has been given a power of attorney, or a court-appointed guardian. **Please attach the legal document** that gives you the authority to act on behalf of the enrollee.

Name of Personal Representative: _____
Relationship of Personal Representative to Enrollee or Subscriber: _____
Personal Representative Telephone Number:

Daytime Telephone Number: _____
Evening Telephone Number: _____

6. **Procedure to file or revoke this form**

After completing and signing this form, please return it to the address listed below or fax the form to 301-360-8917

**Group Services Department**
**P.O. Box 931**
**Frederick, MD 21705**

For additional information, call Member Services 301-360-8115 or 1-800-709-7604.

To revoke this form, you may submit your request by fax or by mail to the address listed above. Please include your name, and health plan identification number, member number and, if applicable, identify your status as a Personal Representative (see paragraph 5 above) in your correspondence, as well as the name of the person who should no longer have access to your health information.

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By signing where indicated below, you acknowledge your understanding that (i) this authorization is voluntary, (ii) you may refuse to sign this form, and (iii) the released health information may be re-disclosed by the Recipient and may no longer be protected by federal privacy regulations if the Recipient is not a health plan, health care practitioner or other business covered by applicable privacy laws or regulations. You are entitled to a copy of this signed form.

_____ Date: _____

**Signature of Enrollee**
An enrollee's or subscriber's Personal Representative
Or a subscriber acting on behalf of a non-adult enrollee

_____

**Printed name of Enrollee**
An enrollee's or subscriber's Personal Representative
or a subscriber acting on behalf of a non-adult enrollee

# CONTINUATION COVERAGE RIGHTS UNDER COBRA

**Introduction**

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

**What is COBRA Continuation Coverage?**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

**When is COBRA Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee is becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

**You Must Give Notice of Some Qualifying Events**

**For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: City of Takoma Park, Human Resources, 7500 Maple Avenue, Takoma Park, MD 20912, 301-891-7203.**

**How is COBRA Coverage Provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

***Disability extension of 18-month period of continuation coverage***

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide a copy of the SSA determination to City of Takoma Park, Human Resources, 7500 Maple Avenue, Takoma Park, MD 20912, 301-891-7203 within 60 days of the date of the disability determination, the date of the qualifying event or the date coverage was lost or would be lost under the plan (whichever is later) and before the end of the first 18-months of continuation coverage.

***Second qualifying event extension of 18-month period of continuation coverage***

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**If You Have Questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

**Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**Plan Contact Information**

City of Takoma Park - Human Resources
7500 Maple Avenue, Takoma Park, MD 20912
301-891-7203

## *** NEW COBRA CONTINUATION COVERAGE REQUIREMENTS ***

The American Recovery and Reinvestment Act provides a subsidy for COBRA coverage and imposes a number of requirements on employers.

**Subsidy Eligibility**

An employee or dependent that loses coverage under a group health plan from September 1, 2008 until December 31, 2009 is eligible for a COBRA subsidy if the loss of coverage is the result of the employee's involuntary termination of employment. These former employees are then referred to as qualified beneficiaries.

**Subsidy Amount**

Qualified beneficiaries will be required to pay 35% of the COBRA premium for up to nine months.

**Subsidy Period**

The subsidy will apply beginning with the qualified beneficiary's premium payment for the first period of coverage following enactment and will continue for nine months.

# COBRA continued

**Termination of Subsidy**

The COBRA subsidy will cease once a qualified beneficiary becomes eligible for coverage under another group health plan or Medicare. If the qualified beneficiary becomes eligible for coverage under another group health plan or Medicare during the subsidy period, the qualified beneficiary must provide notice of the availability to the employer and/or the Plan. Failure by the employee to provide this notice will result in them being assessed a penalty of 110% of the improperly paid subsidy.

**Income Limitation**

A qualify beneficiary is not entitled to the COBRA subsidy during a year in which they are the taxpayer whose federal modified adjusted gross income exceeds $145,000 (or $290,000 in the case of a taxpayer filing a join return).

**Waiver**

Qualified beneficiaries may make a one-time election to waive the COBRA subsidy.

*This is an abbreviated summary of the COBRA subsidy. You should visit www.dol.gov for more information regarding the subsidy, model notices, appeals, etc.*

# CONTACTS

**City of Takoma Park**
Johnathan Edmund
Human Resources Analyst
301-891-7203

**UnitedHealthcare**
Member Services- 800-842-8000
www.uhc.com or www.myuhc.com

**Aetna**
Life/AD&D Member Services- 800-523-5065
Long-Term Disability Services- 877-465-0424
www.aetna.com

**Vision Service Plan**
Member Services- 800-877-7195
www.vsp.com

**Colonial Life**
Member Services- 800-325-4368
www.coloniallife.com

**Magellan - Employee Assistance Program**
Member Services- 800-523-5668 or
Hearing Impaired/TTY 1-800-882-7610
www.MagellanHealth.com

**State of Maryland Retirement**
Member Services- 800-492-5909
www.sra.state.md.us

**I.C.M.A. Retirement Corporation**
Member Services- 800-669-7400
www.icmarc.org

**Legal Resources**
Member Services- 800-728-5768
www.legalresourcesplan.com

**Montgomery County Employees Federal Credit Union**
Member Services- 301-279-1964
www.mcefcu.org

**Employee Benefit Center (EBC)**
24/7 on line access to Employee Benefits
www.benefitspassport.com
Username: city
Password: takoma

# NOTES